

SERFF Tracking Number:	GRTT-126919411	State:	Arkansas
Filing Company:	Guarantee Trust Life Insurance Company	State Tracking Number:	47504
Company Tracking Number:	APPL3-10		
TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
Product Name:	APPL3-10		
Project Name/Number:	Life Application/APPL3-10		

Filing at a Glance

Company: Guarantee Trust Life Insurance Company

Product Name: APPL3-10

SERFF Tr Num: GRTT-126919411 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed

State Tr Num: 47504

Sub-TOI: L08.000 Life - Other

Co Tr Num: APPL3-10

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Gillian Liang

Disposition Date: 12/13/2010

Date Submitted: 12/09/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Life Application

Status of Filing in Domicile: Pending

Project Number: APPL3-10

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 12/13/2010

Explanation for Other Group Market Type:

State Status Changed: 12/13/2010

Deemer Date:

Created By: Gillian Liang

Submitted By: Gillian Liang

Corresponding Filing Tracking Number:

Filing Description:

We are submitting life application form APPL3-10 for your Department's consideration and approval.

This form is new and will not replace any previously approved form.

We would appreciate general approval of this application so that it may be used with life policies approved by your state.

We are filing the proposed insureds' information in items 1 and 2, the plan and billing in items 3, 4, 5 and 6 of the application as variable. It is not our intention to make any changes that would cause this application to be out of compliance with any statutory requirements.

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This form is printed by our computer and laser printer. We reserve the right to use a different font (type face) when and if a new font becomes available.

We would appreciate any consideration you could extend toward prompt approval of this filing. If I can be of further assistance in this approval process, please feel free to call me toll free at 800-338-7452, ext. 5410, or call me direct at 847-904-5410, or e-mail me at glia@gtlic.com.

Company and Contact

Filing Contact Information

Gillian Liang, Senior Compliance Analyst glia@gtlic.com
 1275 Milwaukee Ave. 847-904-5410 [Phone]
 Glenview, IL 60025 847-699-0093 [FAX]

Filing Company Information

Guarantee Trust Life Insurance Company CoCode: 64211 State of Domicile: Illinois
 1275 Milwaukee Avenue Group Code: 687 Company Type: Mutual
 1275 Milwaukee Avenue Group Name: State ID Number:
 Glenview, IL 60025 FEIN Number: 36-1174500
 (847) 460-4772 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: Filing fee for application is \$50.00.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Guarantee Trust Life Insurance Company	\$50.00	12/09/2010	42801320

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/13/2010	12/13/2010

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Disposition

Disposition Date: 12/13/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Life Application		Yes

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Form Schedule

Lead Form Number: APPL3-10

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	APPL3-10	Application/ Life Application Enrollment Form	Initial		51.600	APPL3-10.pdf

Application for Life Insurance to:

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Ave. ■ Glenview, Illinois 60025

PROPOSED INSURED

1. Name

(Print last name, first name and middle initial)

Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____

Work/Cell Phone (____) _____

Country of Birth _____ Date of Birth ____/____/____
MM DD YYYY

Age ____ Gender ____ Height ____ ft ____ in Weight ____ (in lbs)

Social Security Number _____

E-Mail Address _____

Beneficiary: Primary: _____
Name

Relationship _____ E-Mail Address _____

Contingent: _____
Name

Relationship _____ E-Mail Address _____

2. ☐ Spouse Optional Rider (Renewable and Convertible Term)Name _____
(Print last name, first name and middle initial)

Relationship _____

Country of Birth _____ Date of Birth ____/____/____
MM DD YYYY

Age ____ Gender ____ Height ____ ft ____ in Weight ____ (in lbs)

Social Security Number _____

Beneficiary: Primary: _____
Name

Relationship _____ E-Mail Address _____

Contingent: _____
Name

Relationship _____ E-Mail Address _____

PLAN AND BILLING

3. Proposed Insured: Base Plan – 20 Year Level Term Life Insurance Face Amount: ☐ \$25,000 ☐ \$50,000 ☐ \$100,0004. Spouse Optional Rider ☐ 20 Year Renewable and Convertible Term Rider Amount: ☐ \$25,000 ☐ \$50,000 ☐ \$100,0005. Children Optional Rider ☐ Children's Term Rider Amount: ☐ \$10,000

Name of Children (Print last name, first name and middle initial)	Relationship	Gender	Date of Birth	Age	Country of Birth	Height Ft. In.	Weight In lbs.	Social Security #

6. Premium Mode: ☐ Monthly Bank Draft ☐ Monthly Credit Card7. Send Billing & Correspondence to: ☐ Insured ☐ Owner ☐ Payer Social Security # for Owner/Payer: _____

Name of Owner/Payer (if other than Proposed Insured): _____ Relationship _____

Address: _____

EMPLOYMENT INFORMATION

8a. Occupation of Proposed Insured: _____ Duties: _____ Annual Income: \$ _____

8b. Occupation of Spouse: _____ Duties: _____ Annual Income: \$ _____
(Complete if Spouse Optional Rider is selected)

OTHER INSURANCE

9. Does any person proposed for insurance currently have life insurance in-force, have life insurance or an application pending, or is the person contemplating purchasing life insurance?..... ☐ Yes ☐ No
If Yes, give complete details _____10. Will this coverage applied for replace or change any life insurance currently in force?..... ☐ Yes ☐ No
If Yes, please list name of the person proposed for insurance, face amount of insurance, and/or benefit amount;
also provide the Company name.

UNDERWRITING

11. Has any person proposed for insurance used any tobacco products in the past 12 months?..... ☐ Yes ☐ No
12. Has any person proposed for insurance ever been declined, restricted, rated up, or postponed for any kind of life insurance?..... ☐ Yes ☐ No
13. Has any person proposed for insurance, in the past five years, made or now contemplate making flights as a pilot, student pilot, crewmember, or observer or participated in or plan to participate in skydiving, parachuting, hang gliding, underwater diving, organized racing, or any other hazardous sport? If yes, complete and submit Avocation Questionnaire..... ☐ Yes ☐ No
14. Has any person proposed for insurance had their driver's license suspended, revoked, or been charged with a "DUI" within the last three years?..... ☐ Yes ☐ No
If yes, please list that/those person's driver's license number(s): _____
15. Has any person proposed for insurance been convicted of a felony or is any person proposed for insurance currently on probation or parole?..... ☐ Yes ☐ No
16. Is any person proposed for insurance not a United States citizen or legal alien resident of the United States?..... ☐ Yes ☐ No
17. Please give the complete details for questions 11 –16 answered "Yes." Include applicable name(s) and item number(s) below:
- _____
- _____
- _____

MEDICAL INFORMATION

18. To the best of your knowledge and belief, has any person proposed for insurance had, been diagnosed as having, been advised to seek treatment for, or been treated by a medical practitioner within the past 10 years for any of the following (circle the appropriate condition for each "Yes" answer):
- a. Asthma, emphysema, bronchitis, chronic obstructive lung disease, or other disease of the respiratory system?..... ☐ Yes ☐ No
- b. High blood pressure, stroke, heart attack, congestive heart failure, heart or blood vessel surgery or procedure, peripheral vascular disease, heart murmur, chest pain or angina, or other disease of the cardiovascular system?... ☐ Yes ☐ No
- c. Disease of the liver, kidney, bladder, pancreas, stomach or intestine?..... ☐ Yes ☐ No
- d. Paralysis, convulsions, epilepsy, anxiety, depression, psychosis, or other mental or nervous disorder of the brain or nervous system or problems with memory?..... ☐ Yes ☐ No
- e. Protein, sugar, blood or pus in the urine, disorder of the prostate, breast or reproductive organs, or internal or skin cancer, melanoma, leukemia, or tumor? ☐ Yes ☐ No
- f. Diabetes, or disease of the pituitary, adrenal, or thyroid gland or collagen disease? ☐ Yes ☐ No
- g. An immune deficiency disorder, AIDS, AIDS Related Complex (ARC), or tested positive for the antibodies to human immunodeficiency virus (HIV)?..... ☐ Yes ☐ No
- h. Alcohol or drug use, or used drugs, such as heroin, cocaine, amphetamines, or other narcotics not prescribed by a doctor?..... ☐ Yes ☐ No
19. Has any person proposed for insurance within the past 5 years, consulted or been treated by a member of the medical profession for a condition other than previously stated above or been advised to have surgery not yet completed?..... ☐ Yes ☐ No
20. Has any person proposed for insurance currently taking any prescription medication(s) or been advised to take any medication(s)?..... ☐ Yes ☐ No
21. Please give complete details to any "Yes" answers for question 18a-h and questions 19 - 20. Include names, addresses, and phone numbers for doctors, and dates and reasons for treatment. Be sure to indicate the person proposed for insurance to which the "Yes" answer applies, and the question number(s): _____
- _____
- _____
- _____
- _____

NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false, incomplete, or deceptive statement of a material fact may be guilty of insurance fraud.

AUTHORIZATION

I (We) authorize Guarantee Trust Life Insurance Company (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction, such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) authorize all sources, except the Medical Information Bureau Inc. to give such records to any agency employed by the Company to collect such information. I (We) agree that this Authorization will be valid for 24 months from the date signed, and know that I (We) or my (our) authorized representative may have a photocopy of it. I (We) have read or had read this authorization and I (we) have also received a copy or will be provided a copy of the "Notice to Applicant, Parts 1 and 2" and the Description of Information Practices form prepared by the Company (if required in your state).

I (We) understand that I (we) have the right to revoke this Authorization, in writing, at any time by sending written notification to the Company at the above address. I (We) understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as the Company has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to the attention of the Underwriting Manager.

I (We) understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by the Company in accordance with federal or state law. I (We) also understand that my (our) application for insurance can be declined if I (we) choose not to sign this Authorization.

ACKNOWLEDGEMENTS: I (We) represent and agree as follows: 1) That the statements contained in the application concerning past and present health are complete, true, and correct. 2) Any insurance issued as a result of this application shall, together with this application, constitute a single and entire contract of insurance. 3) No other person is authorized to accept risks, pass on insurability, make or modify contracts, or waive any of the Company's rights or requirements. 4) Any insurance issued as a result of this application will not take effect unless and until the full first premium is paid and the policy is delivered during such person's lifetime and while such person is in the condition of health set forth in this application. 5) Provisions concerning exceptions, exclusions, limitations, and renewal in the insurance which has been applied for, are understood.

CAUTION: If your answers on this application are incorrect or untrue, Guarantee Trust Life Insurance Company has the right to deny benefits or rescind your coverage.

X _____ Signature of Proposed Insured	Date	X _____ Signature of Applicant/Owner (if other than Proposed Insured)	Date
X _____ Signature of Spouse (Insured under Renewable and Convertible Term Rider)	Application Signed/Dated in: _____		City State

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Supporting Document Schedules

	Item Status:	Status
		Date:
Satisfied - Item:	Flesch Certification	
Comments:		
Attachment:		
Readability Certification.pdf		

CERTIFICATE OF READABILITY

Form Number(s): APPL3-10

Flesch Test Score(s): 51.60

I hereby certify that to the best of my knowledge and belief, the above form(s) meet the minimum reading ease requirements of your Department. The Flesch Reading Ease Test score(s) are listed above.

GUARANTEE TRUST LIFE INSURANCE COMPANY



Allan J. Heindl, FLMI, HIA, AIRC
Vice President – Product Approval & Compliance

Date: November 22, 2010